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Shared decision making in Taiwan

Partizipative Entscheidungsfindung in Taiwan

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ABSTRACT

The paper aims to introduce the current status of shared decision making (SDM) in Taiwan under its mixed health care system and single-payer health insurance system. With experiences in promoting both evidence based medicine and patient safety, the Joint Commission of Taiwan has implemented a nationwide SDM program under the aegis of the Ministry of Health and Welfare since 2016, incorporating multiple approaches such as developing patient decision aids (PDAs), executing the Medical Decision Aids Campaign, establishing a SDM platform, and integrating SDM in clinical practice. In this article, we share the positive and negative responses to the SDM program from hospitals, health care providers, and patients.

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ZUSAMMENFASSUNG

In diesem Beitrag stellen wir den aktuellen Stand der partizipativen Entscheidungsfindung (PEF) in Taiwan unter den Bedingungen eines gemischten Gesundheitsversorgungssystems und eines Krankenversicherungssystems nach dem Single-Payer-Modell vor. Auf der Grundlage ihrer Erfahrungen mit der Förderung von evidenzbasierter Medizin und Patientensicherheit hat die Gemeinsame Kommission in Taiwan seit 2016 begonnen, unter der Schirmherrschaft des Ministeriums für Gesundheit und Soziales ein landesweites PEF-Programm zu implementieren, das vielfältige Ansätze wie die Entwicklung von Entscheidungshilfen für Patienten, die Durchführung einer Kampagne zum Thema medizinische Entscheidungshilfen, die Einrichtung einer PEF-Plattform und die Integration von partizipativer Entscheidungsfindung in die klinische Praxis umfasst. Darüber hinaus berichten wir über die positiven und negativen Reaktionen auf das PEF-Programm vonseiten der Krankenhäuser, der Gesundheitsdienstleister und der Patienten.

Background of health care system in Taiwan

In Taiwan, a small island (36,193 km^2) with a population of approximately 23.5 million, health care is delivered by a public-private mix of 485 hospitals and 21,845 clinics, including medical centers and primary clinics in both Western and traditional Chinese medicine. Taiwan has adopted since 1995 a *single-payer national health insurance (NHI) system* covering around 99.6% of the total population [1]. This compulsory NHI plan is jointly financed by payroll contributions from employers and employees and government subsidies. Two decades after its implementation, the NHI system has obtained some impressive results. Its satisfaction rate has stayed around 80% during the recent two years [1]. It has also received recognition from international medical communities and media for its remarkable accessibility, comprehensive coverage, short waiting time, affordable cost, high coverage rate, and contribution to the establishment, as well as continuous expansion, of

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a nationwide research databank [2–4]. In spite of these strengths, however, the system has also been criticized for its need to enhance the quality of care in outpatient visits, referral system, and financial sustainability [3]. The ratio of national health expenditures (NHE) to gross domestic product (GDP) in Taiwan fell in the range of 6.1% to 6.7 during the period from 2005 to 2015, indicating a likelihood of underfunding by the international standards [2]. Easy access of health service and free choice of visit contribute to a steep number of outpatient visits reading an average as high as 15 times per person per year, which is higher than all the numbers of medical consultation listed in Organization for Economic Co-operation and Development [5]. While the payment varies along with the type of hospital visited (e.g. a private clinic or a medical center) and the type of service utilized (outpatient or emergency) and there is a deduction for referred visits, the NHI system has been caught in the quagmire of patients' overutilizing emergency service and medical centers. A physician may need to treat over 50 patients on a daily basis, making each visit unavoidably short. Meanwhile, the long working hours of physicians and nurses have become an issue receiving more and more attention in recent years, and laws are accordingly amended and enforced to address the issue [6].

Legislative efforts to involve patients in health care decisions

In response to rising awareness of patients' rights, the government has made legislative efforts to safeguard patients' participation in their health care decisions in Taiwan. The concept of informed consent was first introduced in the *Medical Care Act* promulgated in 1986, which required a written informed consent from the patients before surgeries. The *Physicians Act* also requests physicians to provide a patient with comprehensive information about the treatment plan, intervention, medication, prognosis, and possibly adverse effects of his or her disease. For other medical care issues, notably the do-not-resuscitate order, patient's participation and autonomy are ensured in the *Patient Self-Determination Act* enforced in 2015. However, the process of consenting focuses on the provision of clear and adequate information; the inclusion of patients' voice in the process has yet to be precisely defined and explicitly documented. Meanwhile, there are great needs to mend the gap of communication between patients and the care providers. According to the annual report of *Taiwan Patient Safety Reporting System*, communication problems between healthcare providers and patients accounted to 31.6% of the underlying reasons of communication factors in patient safety events in 2014 [7]. Moreover, one of the frequent causes of medical disputes in court is inadequate explanation of the medical procedures in 1987 to 2013. On the other hand, patient involvement has been one of the *Taiwan Patient Safety Goal* since 2004. Patient and their family are encouraged to actively participate in the care they received. The public survey during 2013 to 2015 showed a gradual increase of people willing to respond and cooperate with healthcare workers [7]; which supported the opportunity to introduce new concepts and tools for improving the doctor-patient communication.

The process of communication is important, as well as the basis of practice. Evidence based medicine (EBM), a clinical practice consistent with the current best evidence, has been proposed as a core competence to help health professionals improve care quality [8,9]. EBM has been promoted and implemented at several hospitals since 1996 in Taiwan, and a nationwide EBM project supervised by the *Ministry of Health and Welfare* (MOHW) was launched in 2002 to promote both the concpets and practice of EBM in teaching, service, and research. In 2000, the *Joint Commission of Taiwan* (JCT) held the *Healthcare Quality Improvement Campaign* (HQIC) to encourage hospitals and medical professionals to help better healthcare quality and clinical practice with the 5 steps of EBM: ask, acquire, appraise, apply and audit [8,9]. For promoting EBM eduction, the campaign held a competition that was found effective in enhancing participants' EBM knowledge, skills, and behavior [9]. The prior experience could help to prepare the medical societies for incorporating evidence based practice (EBP) into shared decision making (SDM). SDM became a new approach for promoting patient-centered healthcare in Taiwan.

National approaches to SDM

SDM had already been introduced and practiced in daily medical care at several hospitals in Taiwan prior to the formulation of related policy to put it into systematic implementation in the entire healthcare system [10]. As extensive research indicates that building a global environment (macro level) helps expedite the formation of a patient-centered care team and the performance of its functions [11], the government approached SDM policy formulation by holding a series of specialist consultations and consensus meetings.

The *Ministry of Health and Welfare* (MOHW) joined force with patient groups, professional organizations, and medical and health care institutions like JCT and TMA (Taiwan Medical Association) to develop SDM policy and promotion program. In order to implement SDM for daily medical practice at hospitals and clinics in Taiwan, a nationwide SDM program has been initiated since the spring of 2016, adopting multiple approaches coordinated systematically, including developing the patient decision aids (PDAs), establishing a SDM platform, and implementing SDM in clinical practice.

Aware of the capability of patient decision aids in supporting SDM in clinical practice [12], MOHW and JCT worked with the hospitals to develop Taiwan-based PDAs in line with local values, culture, social context, and medical regulations. The PDAs prototypes were tested before they were introduced to the public. All of the PDAs are developed in compliance with the EBM guidelines incorporating the following steps: First, answerable clinical questions from the patient's viewpoints are asked. Second, the target population which coincides with the term "patient, PICO" is clarified. Third, options for treating the medical condition in question which coincide with the term "intervention, PICO" are explored and explained. Fourth, the benefits/risks of each option which coincide with the term "comparison, PICO" are compared with consideration of the patients' value and preference. The last step clarifies and assesses the outcome [9,13,14]. Moreover, the PDAs include instruction brochures and demonstration videos used by 20 patients for revision and verification of their comprehensibility and usability in a pilot study.

MOHW and JCT also developed SDM training programs and launched the *Medical Decision Aids Campaign* to encourage medical and healthcare organizations to practice the SDM procedures and promote both the use and the development of PDAs. In 2016, 22 themes were suggested by professional medical associations to be granted priority for PDA development, and a total of 174 PDAs were developed by hospitals participating in the campaign (Table 1). A committee composed of esteemed healthcare professionals and EBM specialists was organized to assess the effectiveness of the aforementioned PDAs based on the criteria and checklist of the International Patient Decision Aid Standards (IPDAS) Collaboration [15], resulting in the accreditation of 57 PDAs subsequently uploaded to the SDM Platform for medical care providers use (http://sdm.patientsafety.mohw.gov.tw/AssistTool/Category?sn=24).

As demonstrated by the experiences of countries pioneering the development of SDM, such as Australia, Canada, the United Kingdom, and the United States, a SDM platform plays a crucial role in facilitating the implementation of SDM at